INFORMATION BULLETIN: TESTIMONY TO LONG TERM CARE COMMISSION

TESTIMONY OF MEDICAL UPDATE PANEL

March 4, 2021

http://www.ltccommission-commissionsld.ca/transcripts/pdf/Medical_Update_Panel_Transcript_March_4_2021.pdf

- Long term care resident vaccine uptake – +90% Staff uptake – about 55% (Pg. 7/8)
- As of March 3rd, 2021 1,897 residents had died in the second wave. (Pg. 8)
- "there were some improvements, but certainly, the overall sector did fall short and did reach that point of eclipsing that first wave death toll." (Pg. 10)
- Dr. Allison Mc Geer – "it is not possible to change the behaviour of 75,000 staff members who, generally speaking, have deeply inadequate training and education in a four-month period. You're not going to change culture in an entire sector in that period of time." (Pg. 11)
- Dr. Allison McGeer – "a number of proposals went to the Ministry about what could be done; and all of them were deemed by the Ministry to be too expensive." (Pg. 11)
- No plans put in place to move residents out of homes in outbreak because it was considered too expensive (Pgs. 14/15)
- Dr. Sinha – "long-term care homes have, on average, three and a half times the number of respiratory outbreaks in a given year that retirement homes will have, where people are living in individual rooms." "…in these sorts of congregate settings, this is where you're going to have these issues that really need to be top of mind." (Pg. 15/16)
- **Dr. Sinha - "it's almost that we've normalized, on an annual basis, kind of the fact that every fall and winter, we will lose a few thousand people, because that's what happens. Flu comes in, it gets a bunch of people, and we just fill the beds with new people, and then the cycle starts again." (Pg. 16)**
- Dr. Sinha – "IPAC with PPE means nothing, in my view, unless you have stable and adequate staffing." (Pg. 18)
- Quebec paid for staff training and hired 8000 people dedicated to the facilities (Pg. 20)
- **Dr. Sinha – "a lot of the new agency models that were popping up were, especially in a gig economy, where you don't want to get caught in the legal issue that if you treat them like employees, you might actually have to pay them like employees. So we literally have some agency workers where I could actually sign up for this PSW shift on an app, I'll get paid, say, $35 an hour versus the $29 I might get at the highest unionized rate. So I'll get 35 bucks an hour. And what it tells you is, "bring your own PPE". I was calling it, saying like "BYOPPE". You know, "bring your own PPE" to the party." (Pg. 21)**
- No dedicated infection prevention and control specialists – not part of LTC culture (Pg. 26)
- Dr. Sinha calls for dedicated funding for nursing homes to hire infection prevention and control specialists (Pg. 36)
- Dr. Boyd calls for a PSW or housekeeper to be the infection prevention and control lead person in a facility????? (Pg. 39)

- Discussion of breakdown in leadership in the facilities and resignations of Medical Directors (Pg. 52)
- Medical Directors never received Medical Director training in spite of that being recommended years ago by another inquiry. Dr. Hugh Boyd – "we are suffering a massive catastrophe and loss of opportunities of leadership because that recommendation wasn't implemented (Pg. 53)
- "Long-term care homes often hire a medical director, not knowing what the job description of a medical director is." (Pg. 54)
- Dr. Boyd calling for the creation of a Medical Officer of Health for Long-Term Care.(Pg. 55)
- Dr. Hugh Boyd "**We created a similar group in Hamilton in a crisis, under the amazing leadership of Dr. Tammy Packer. She brought together, in two days, a community of medical directors and attending physicians; some who refused to go into the home, most who ended up going into the home thanks to this amazing, supportive and collaborative team. We developed an order set to minimize variability, to provide a standard level of care that was coached by internal medicine and infectious disease, and we incorporated palliative care as well, so that when a crisis happened and you have thousands of people you care about so deeply dying, you have a simple, efficient tool so that you can provide quality care to everyone."** (Pg.56)
- Dr. Nathan Stall – **"community dwelling residents, 81.4 percent were hospitalized prior to death; only 22.4 percent of long-term care residents were." "The community dwelling residents, that stayed stable from 75 to 80 percent. But in the long-term care dwelling population, it varied between 15.5 percent, which actually happened in March and April. The real highest concentration of deaths, had the lowest amount of transfers to hospital, and it ranged from 15.5 percent to 41.2 percent in terms of monthly transfers to hospital prior to death."** (Pg. 65)
- **Dr. Hugh Boyd – re: policy of not transferring LTC residents to hospitals – "Not from the government, but we did see policies issued by emergency departments. And sometimes the medical director was also the medical director of the emergency department, and we did see firm recommendations that patients will not be transferred. <u>This is consistent with decades of brutal ageism and discrimination against long-term care. You may have heard the word "GOMER", a horrific term, short form for "get out of my ER", popularized on television."</u> As Dr. Stall reported, <u>it is the worst outcome from far too long of discrimination that should have been crushed a long time ago</u>.** (Pg. 66/67)
- **Dr. Samir Sinha – transfer rates to hospital for pneumonia, urinary tract infections, heart failure or chronic obstruction pulmonary disease – those transfer rates to hospital were down anywhere from 36-51%** (Pg. 68)
- **Dr. Sinha – "**in Ontario, which was surprising to me, accreditation is optional. It is funded, 36 cents per resident per day, first of all, if you do participate in it. But 15 percent of homes do not participate in this process, which I think is really about quality improvement and raising the standard. And then what we see is that you have two potential accreditors allowed to

work in Ontario: One that the majority of the not-for-profit municipal homes use -- and Dr. Boyd can speak about experience with one versus the other -- that the majority of the for-profits use, that's a U.S.-based firm, that may not understand or design their standards around the Canadian 6context or what's really important about what we do in Canada." (Pg. 79) Ontario is the only province where accreditation is optional. **Commissioner Coke asks the key question: "**But what is missing in that process? If you're saying all of 85 percent of them have their accreditation, but they're in the condition that they are in; what is somebody to make of that?" Dr. Sinha responds "there is a gap". Commissioner Coke goes on to say "in terms of having a quality management mindset. It doesn't appear to be there for a lot of these homes." (Pg. 80) **Dr. Sinha "for-profits have generally tended to rely on a U.S. provider, which by my understanding, for example, it's not as hard to attain accreditation, you know, through that mechanism and, frankly, it's cheaper as well."** (Pg. 81)

- COMMISSION CHAIR FRANK MARROCCO: "wasn't Tendercare Living accredited? DR. SAMIR K. SINHA: It was accredited, absolutely. COMMISSION CHAIR FRANK MARROCCO: What we heard, I think it was from North York General about what they found when they went in there –DR. SAMIR K. SINHA: Right. COMMISSION CHAIR FRANK MARROCCO: --would cause you to reflect on the accreditation. (Pg. 82)
- COMMISSION CHAIR FRANK MARROCCO: "I'm having some difficulty with the fact that there's a waiting list. So you have an inspection, you don't do very well, that's public, let's assume you make that public. But there's a waiting list, and it's a significant list, as you well know. So then you really don't have a choice anyway." (Pg. 89)
- COMMISSION CHAIR FRANK MARROCCO: I didn't mean to -- it is unacceptable, I think we all agree. I was just saying that, you know, if you have a market, and you're not performing well, well, I'll go to somebody else. But my problem here is, I have no place else to go so, you know, it's -- I don't want to pick a particular home, but you're going there or you're staying on the waiting list for a much longer period. And at the same time, we're told that the median time people spend in long-term care is somewhere around 12 to 18 months. So you might spend longer on the waiting list than you have left. And so I was just curious what you thought of that when you were dealing with inspections. I have no problem with the idea of a robust inspection regime. I can't imagine how you have effective regulation without it. But this is, it seemed to me, a complicating factor.(Pg. 90/91)
- **Dr. Sinha – "**CIHI has demonstrated that between 10 to 30 percent of those who are on our waiting lists right now, who are in our long-term care homes right now, could have been cared for at home, you know, with existing resources and programs. But because we don't necessarily have the flexibility of service delivery models and that, when we find that sometimes people are defaulting to then living in the hospital or living, you know --or having to just wait and go into a home." (Pg. 93)
- **Dr. Samir Sinha** "**When the Ministry of Health's own numbers -- and this is what I released in November, in our Bringing Long-Term Care Home Report through the 5NIA -- it was really focusing on this notion that, 6you know, we can actually provide much better holistic and integrated care for a lot cheaper than it costs to actually provide care in a home, to some**

people, not all. But yet we're not willing to actually build our entire system to think about how we need to care for an ageing population. Because this notion that we simply need to just build thousands of more beds, you know, I hesitate on building more beds, when we don't even have our current program working well within the beds that we currently have. I think we need to start there. I think there are actually ways in which you can provide high quality long-term care not within a building as well. And I think we could better serve many of the people who are currently on our waitlist, and frankly people in our homes."(Pg. 95)

- Dr. Sinha - **I think the key that we need to focus on here is if you look at -- you know, again, this is where I always go to my favourite country of Denmark. Frankly, two-thirds of the long-term care they provide are in people's homes. The infrastructure needs are already met." "only a few hundred people out of the 700,000 receiving government-funded home care actually got COVID, and only a handful of those people actually died. And that's partly because just going into people's homes separately, you have to don and doff. You actually are forced to actually apply some IPAC principles before you're going in and out." (**Pg. 97/98)
- Dr. Sinha – "I think the fundamental piece is that we can actually afford to provide more long-term care options in people's homes. And that's something that we did between 2012 and 2017. That's the story that often doesn't get told. **But we created 30,000 more spaces with extra funding in home care, for long-term care equivalent people.** These are, they would meet the same criteria to be in a home, to stay in their own homes, because we had more dollars in the home care system. Are those dollars being used well? No. Can they be used better? Absolutely." (Pg. 98)
- Dr. Sinha – "But the key is, we actually have demonstrated a la Denmark, that by investing more in our home care system, we can actually provide more people the option to stay at home, and often for a lot cheaper. **Because the FAO, the Financial Accountabilities Office will tell you, $230 a day is our current cost to provide care for a person in a long-term care home. It's $103 a day for a person in Ontario receiving home care, if they are a long-term care equivalent resident. We have about 120,000 people 75 and older, currently receiving care in their own homes, who are long-term care equivalent versus the 80,000 who are actually equivalent individuals, if you match them, who are living in a long-term care home. That's what we've achieved by investing more in home care. And I'm not saying it's an either/or, I think it's a both/and. But we have a very lopsided system right now."** (Pg. 99)
- So we actually created in 2017 an Ontario Dementia Strategy. We're very proud of that strategy. **The final PS services in year three never got funded**. **And that actually talked about networks support that were based in primary care that were really supporting us being able to do early diagnosis and intervention, linking people early into home care support. Because when you get people those supports early, it actually prevents that quick, rapid deterioration, but then gets them on a crisis placement list via a hospital bed and then into the system.** When you actually look at the people living with cognitive impairment, you're absolutely right, 90 percent of the people in long-term care have cognitive impairment. The majority of people receiving government-funded home care in Ontario have cognitive

impairment. But the key is, **if you even look at the types of people with cognitive impairment in our long-term care homes, CIHI notes that a number of them have mild cognitive impairment, like not FCI, but more mild dementia, that their needs are actually not that heavy and they could be met well at home**.(Pg. 102)